North Carolina Department of Health and Human Services
Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011• Fax 919-508-0951
Michael Moseley, Director

Division of Medical Assistance
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-855-4100• Fax 919-733-6608
L. Allen Dobson, Jr. MD, Assistant Secretary for Health Policy and Medical Assistance

February 20, 2007

MEMORANDUM

TO: Legislative Oversight Committee
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
NC Assoc. of County DSS Directors
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
MH/DD/SAS Stakeholder Organizations

FROM: L. Allen Dobson, Jr., MD

Mike Moseley

RE: Implementation Update #23: Various Clarifications Related to the CAP-MR/DD Waiver

This update contains clarification on a variety of issues related to CAP-MR/DD.

Revisions to the CAP-MR/DD Manual:

Since the implementation of the CAP-MR/DD waiver in September 2005, a number of significant changes have occurred – primarily the transition from local approval to utilization review for CAP-MR/DD services and Targeted Case Management through Value Options. Revisions to the Manual are occurring and will be posted at completion. Once complete, revisions to the CAP-MR/DD Manual must be reviewed and approved through DMA's Physician's Advisory Group (PAG) and through rule-making. Until such time as that review process is complete, the Manual will be in draft form.

Request for Authorizations of CAP-MR/DD Services through Value Options:

In the July 2005 training on CAP-MR/DD and Targeted Case Management (TCM) provided by the Division of Medical Assistance (DMA), Value Options and DMH/DD/SAS, information was presented regarding responsibility for submitting requests for authorizations. This information was summarized in a grid posted July 25, 2006 to the DMH/DD/SAS website titled, *Authorization of CAP-MR/DD and Targeted Case Management through Value Options*. The grid was updated in November 2006. There continues to be confusion in regard to

responsibility for requests for authorization of CAP-MR/DD services. Please note the following:

- Requests for authorization of services for an initial Plan of Care or Continued Need Review are the responsibility of the case manager. If approved, Value Options will send each provider of discreet services an authorization.
- At the six month interval it is the responsibility of the direct service provider to request re-authorization of services if there is no change in service or duration and frequency. A change in services, or duration and frequency of services requires a revision/update to the Plan of Care and is the responsibility of the case manager.
- Case managers are responsible for requests for authorization and re-authorization of case management.

A grid outlining timelines for requests for authorizations, as well as required documents for submissions, is posted to the CAP-MR/DD page of the DMH/DD/SAS website at www.ncdhhs.gov/mhddsas/cap-mrdd/operations/index.htm.

Process, Including Appeals, for Plans of Care over $85,000:

The CAP-MR/DD waiver, on Page 3 of Appendix A - Administration, requires that utilization review will include criteria for review by the Chief of Clinical Policy with the DMH/DD/SAS or his designee for Plans of Care in excess of $85,000.

The following outlines the process for this review which will be included in the revised CAP-MR/DD Manual:

- Utilization review vendor reviews Plan of Care and accompanying documentation to determine medical necessity of services requested based on clinical review of the Person Centered Plan and whether the budget submitted is within the predicted range of level of acuity determined by the utilization review guidelines.
- If the Plan of Care is determined not to meet medical necessity by the utilization review vendor as noted, the utilization review vendor sends a written denial, reduction, or termination notice with appeal rights to the individual/legally responsible person. The decision is made and written notice is issued in accordance with the Division of Medical Assistance's recipient notices procedures. It should be noted that the provider and case manager also receive a copy of the notice. Additionally, only the consumer or his/her legally responsible person can appeal the decision. See note 2 at the end of this section for further information regarding the review process.
- If the Plan of Care is determined to meet medical necessity as noted above, a second level review is requested from the Chief of Clinical Policy or designee with the Division of Mental Health, Developmental Disabilities, and Substance Abuse (DMH/DD/SAS).
- If the Plan of Care is determined to meet medical necessity by the Chief of Clinical Policy/designee based on the second clinical review of the person centered plan and accompanying documentation, a formal decision letter is sent by the Chief of Clinical Policy or designee to the utilization review vendor indicating approval.
- The utilization review vendor submits authorizations for services to specific providers, and an approval letter is sent to the Local Management Entity (LME) indicating Plan of Care approval.
- **New process:** LMEs will receive approval letters from Value Options for all initial Plans of Care and Continued Need Reviews. The LME will submit the Plan of Care approval letter to the local Department of Social Services (DSS) with a copy to the case manager for initial plans. (Upon receipt of the approval letter the local DSS representative enters the CM indicator into the system for new waiver participants.)
- If the services requested do not meet medical necessity based on the second clinical review by the Chief of Clinical Policy/designee of the person centered plan and whether the budget submitted is within the

predicted range of level of acuity determined by the utilization review guidelines, the Chief of Clinical Policy/designee sends a written denial, reduction, or termination notice with appeal rights to individual/legally responsible person. A copy of the letter is also submitted to the utilization review vendor, providers and the case manager. As above, the decision is made and written notice is issued in accordance with the Division of Medical Assistance's recipient notices procedures. See note 2 at the end of this section for further information regarding the review process.

- If an informal hearing is desired, the consumer/legally responsible person must request an informal appeal with the Department of Health and Human Services (DHHS) within 11 days. The Clinical Policy Section of the Division of Medical Assistance will notify the utilization review vendor that an informal appeal has been requested and the utilization review vendor submits authorizations for current services to specific providers until the hearing officer makes a decision. When the consumer currently receives services, the utilization review vendor will authorize the service to continue at its current level or the level requested by the provider, whichever is lower for the pendency of the appeal. If the informal appeal upholds the DMH/DD/SAS or utilization review vendor's decision, the current service will be reduced/terminated 11 calendar days from the date of the hearing decision.
- If an informal appeal is not requested within 11 days, the reduction, denial or termination of identified services will be implemented and the utilization review vendor will submit authorizations for services according to the initial denial, reduction or termination as stated in the notice
- If the consumer/legally responsible person does not request an informal appeal but does request a formal appeal, the consumer/legally responsible person must request the formal appeal within 60 days of the date the notice of denial, reduction or termination was generated. The Clinical Policy Section of the Division of Medical Assistance will notify the utilization review vendor that a formal appeal has been requested and the utilization review vendor will submit authorizations to reinstate services received prior to the date of the notice. For the pendency of the appeal, the utilization review vendor will authorize the service to continue at its current level or the level requested by the provider, whichever is lower. If the final agency decision is upheld current service will be reduced/terminated.

Note 1: Consumer Medicaid Notification Templates may be found on the DMH/DD/SAS website at http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm#forms.

Note 2: Each request submitted must be acted upon within a 'reasonably prompt' time period. Reasonable promptness varies depending upon the nature of the request and the individual circumstances.

Requests for urgently needed services are given the highest priority and acted on within two business days of receipt to avoid endangering the consumer's health. Non-emergency requests will be acted upon within 15 business days of receipt of the request.

If it is determined that further information is needed to make a decision, it will be requested from the provider or case manager within two business days of receipt of an emergent request or 15 business days of receipt of a non-emergent request. The provider or case manager will be allowed another 15 business days to submit the additional information. There may be situations where 15 business days does not allow sufficient time for a response. If a provider or case manager is unable to submit the additional information within 15 business days from the date of the request, he/she must contact the utilization review vendor to request an extension of time. It is not necessary for the provider or case manager to explain the reason for the time extension. The utilization review vendor will allow the provider or case manager no more than an additional 15 business days from the date of the contact to submit the requested information. If there is no response from the provider/case manager or if the provider/case manager does not submit the additional information within the 15 business day time period, the provider/case manager and consumer/legally responsible person will be notified in writing that the request was denied for insufficient information.

Family Members and Legally Responsible Individuals as Paid Caregivers:

As has been previously noted in Implementation Update #22, the DMH/DD/SAS and DMA has received a variety of feedback in regard to the policy ***Services and Supports Provided by Legally Responsible Individuals, Relatives, and Legal Guardians*** which was a component of the most recent Technical Amendment to the CAP-MR/DD waiver. That policy was originally scheduled to be effective as of April 1, 2007, but has been subsequently postponed. It continues to be under review by the Department of Health and Human Services, and it is anticipated that additional information regarding the policy will be forthcoming. **Consumers, family members and legal guardians should not be required to make any changes pertaining to the original policy until additional information is provided.**

EPSDT Coverage and CAP Waivers:

1. Waiver services are available only to participants in the CAP-MR/DD waiver program and are not a part of the EPSDT benefit. However, CAP-MR/DD consumers under 21 years of age can receive EPSDT services IN ADDITION to waiver services. Any request for services for a CAP-MR/DD consumer under 21 years of age must be evaluated under BOTH the waiver and EPSDT. It is IMPORTANT to remember that the conditions set forth in the waiver concerning the consumer's budget and continued participation in the waiver APPLY.

2. A consumer under 21 years of age on a waiting list for CAP-MR/DD services, who is an authorized Medicaid consumer without regard to approval under a waiver, is eligible for necessary EPSDT services without any waiting list being imposed.

3. EPSDT services must be provided to Medicaid recipients under 21 years of age receiving CAP-MR/DD services under the same standards as other children receiving Medicaid services. For example, some CAP-MR/DD consumers under 21 years of age may need daily in-school assistance supervised by a licensed clinician through community support services or personal care services or another non-covered state Medicaid plan service to control/manage symptoms and behavior related to their diagnosed conditions or to assist with activities of daily living. The purposes of community support services listed in the service definition are ameliorative purposes that can be covered under EPSDT, including in the school setting, regardless of whether the CAP-MR/DD consumer meets the specific criteria in the community support service definition.

4. EPSDT services such as personal care services or community support services can be provided to CAP-MR/DD consumers under 21 years of age in the school setting upon appropriate approval.

5. CAP-MR/DD case managers and LMEs cannot deny a request supported by a licensed clinician, either formally or informally. All service requests must be forwarded to Value Options for Medicaid recipients under 21 years of age who receive services under the CAP-MR/DD waiver, as well as for consumers under 21 year of age who have a case manager and receive behavioral health services but are not in the CAP-MR/DD waiver.

6. If a consumer under 21 years of age has a developmental disability diagnosis, this does not necessarily mean that the requested service is habilitative and may not be covered under EPSDT. The EPSDT criteria of whether the service is medically necessary to correct, improve, or compensate for a defect, physical and mental illness, or a condition [health problem], prevent it from worsening; and/or prevent the development of additional health problems apply. Examples include dual diagnoses and behavioral disorders. All individual facts must be considered.

Use of Slots Vacated During the Waiver Year (9/1 through 8/31):

If the LME has individuals who have been served on the waiver during a given waiver year and the individual using the slot moves out of state, is deceased, or placed in an institutional setting, the slot may not be used by another individual until the next waiver year. An individual who is temporarily discharged from CAP-MR/DD due to hospitalization or admission to a developmental center during the waiver year, may utilize the same slot upon discharge back to the community. However, the process for CAP-MR/DD admission upon discharge from the hospital or developmental center must be re-started including completion of a new MR2 and level of care determination.

Continued Need Reviews for Individuals Transitioned from CBS to CAP-MR/DD:

The transition of individuals from CBS to CAP-MR/DD resulted in situations in which the MR2 will expire prior to the birth month and the Continued Need Review (CNR). The process outlined in Implementation Update #13, dated August 3, 2006, should be followed. Update #13 states that "A CNR must be completed during the expiration month of the MR2 and all CNRs must be completed in the birth month after that."

Supervision of Staff Providing Personal Care Services under the CAP-MR/DD Waiver:

There have been a number of questions related to supervision requirements for individuals receiving Personal Care through a Home Care agency. After review of the Home Care rules related to supervision, Section 10A NCAC 131 .1110, Appendix B (Services and Standards) of the waiver application, and the CAP-MR/DD Manual, Section 4.6.9, the following should be followed:

- If waiver Personal Care services are provided by a Home Care agency, Home Care rules apply, and therefore, RN supervision every 60 days is required.
- Agencies other than Home Care agencies providing waiver Personal Care services must adhere to the Qualified Professional supervision.

Implementation Reviews for CAP-MR/DD Providers:

Implementation Reviews are no longer required to be completed by the Local Management Entities (LME) for CAP-MR/DD providers. This review process has been subsumed within the current endorsement and monitoring processes provided by the LME.

Denied Claims for Service Code T1017HI Targeted Case Management

If an agency was providing targeted case management and received a Remittance Advice (RA) stating that the claims were denied based on a limit in the system of $6,000 per recipient year, the agency may request a review. **(The RA's would have an EOB of 9099/9199)**

1. If the denial relates to services delivered after the 9/1/2006 date, please resubmit those claims for processing. The $6,000 limit has been removed from the system effective 9/1/2006.

2. All denials for the months preceding September 1, 2006 require a manual review and override. To do this, DMA will require the following:

   1) copy of the plan that was in effect during the denial month
   2) signed authorization order or signed copy of the POC with a detailed goal oriented case management plan incorporated within the POC
   3) all notes from the case manager for the denial dates
   4) copies of the RAs showing billing by the LME and identifying the denial code 9099 or 9199.

The system denied all claims for each client that exceeded an internal cutoff of $6,000. This limit has been lifted; however, all cases which exceed that amount are subject to audit.

Charts will be reviewed for proper documentation and billing practices. Denied claims will be manually overridden if there is adequate documentation for service; progress notes documenting goals and outcomes as identified in the Plan of Care or Person Centered Plan, appropriate billing of units and verification that denial was 9099 or 9199, which indicated the $6000 excess. The Behavioral Health Section of Clinical Policy (DMA) is continuing to review submitted documentation; however, due to the high volume of charts received, the anticipated time line is extended.

Mail the information to:

Division of Medical Assistance
1985 Umstead Drive
2501 Mail Service Center
Raleigh, North Carolina 27699
Attention: Behavioral Health Section, Clinical Policy

Supported Employment

It is important that the vocational/employment needs of individuals be included as a strong component of the person centered planning process. This includes consideration by the planning team as to whether a referral of the individual to Vocational Rehabilitation (VR) may be appropriate. Supported Employment services furnished under the waiver are not available if the individual can be served under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. If it is determined by the planning team during the person centered planning process that the person would not benefit from a referral to VR but Supported Employment provided through the waiver is appropriate, documentation must be provided in the Plan of Care stating that based on the individual needs of the consumer as identified in the person centered planning process that a referral to VR is not appropriate. There is no longer a requirement that a letter be provided by VR.

Please contact Vivian Leon at DMH/DD/SAS, Vivian.Leon@ncmail.net or (919) 715-2774 or Patricia Kirk at DMA, Patricia.Kirk@ncmail.net or (919) 855-4290) for questions regarding this information.

cc: Secretary Carmen Hooker Odom
Dan Stewart
Mark Benton
DMH/DD/SAS Executive Leadership Team
Sharnese Ransome
Kaye Holder
Wayne Williams
William Lawrence, MD
Tara Larson